COURT ORDER REFERRAL FORM

A

Referring Judge:_____ Court:_____ City/County:_____
Defendant Name:_____
Address:_____ Phone:_____
City & State:_____ Docket #_____
Date of Birth:_____ Driver's License # & State:_____
Convicted of: ❒ DUI: 1st Offense ❒ AC: 1st Offense ❒ .02: 1st Offense
❒ DUI: 2nd or 3rd Offense ❒ AC: 2nd or 3rd Offense ❒ .02: 2nd Offense
❒ DUI: 4th or Subsequent *(Felony)* ❒ AC: 4th or Subsequent *(Felony)* ❒ .02: 3rd or Subsequent Offense
❒ Court Ordered Interlock *(If Applicable)*
❒ MIP (3rd or Subsequent Offense) ❒ Drug Misdemeanor ❒ Other:_____
(Please State Reason)
Date of Conviction:_____ AC Level:_____
Number of Prior DUI/AC Convictions in the Past Five Years:_____ Number of Known Lifetime Prior DUI/AC Convictions:_____

B

PRE-ASSESSMENT PRIOR TO SENTENCING (Optional)
Program name if recommend pre-assessent_____
Judge's Signature:_____Date:_____

C

FIRST OFFENSE ONLY
❒ I do recommend the Department of Justice issue a restricted probationary license.
❒ I do ***not*** recommend the Department of Justice issue a restricted probationary license.
Judge's Signature:_____ Date:_____

D

ORDER *(Please check all appropriate boxes)*
1. ❒ Defendant has already received a pre-sentence evaluation.
2. ❒ Defendant is sentenced to enroll, attend, and complete ACT (assessment, course, and treatment). Treatment is based upon the requirements of MCA 61-8-714/61-8-732.
3. ❒ Defendant is evaluated by a certified chemical dependency counselor (1st offense). If found chemically dependent, defendant must complete treatment.
4. ❒ Treatment is mandatory for the 2nd or subsequent offense.
5. ❒ Defendant is not referred back to this Court unless there is failure to enroll, attend, and complete ACT: or comply with treatment and/or aftercare recommendations of the ACT counselor; or disagrees with the recommendations of the counselor.

ACT Program Name:_____
Address:_____ Enroll by date:_____
Judge's Signature:_____ Date:_____

E

ACT PROGRAM REPORT
❒ Found not chemically dependent *(1st offense only)*
❒ Failed to Enroll
❒ Failed to Complete Assessment/Course (Date)_____
❒ Completed Assessment/Course (Date)_____
❒ ACT Evaluation/recommendation report attached

Treatment Recommendation:
❒ Outpatient/Continuing Care
❒ Intensive Outpatient/Continuing Care
❒ Inpatient/Continuing Care
Defendant: ❒ Agrees ❒ Disagrees ❒ Referred to Judge

_____ _____ _____ _____
Defendant's Signature *Date* *Certified Chemical Dependency Counselor* *Date*

F

TREATMENT PROGRAM REFERRAL
1. Initial Treatment Program Referral - Level of Care:_____
Program Name:_____
Address:_____
City/State/Zip:_____
❒ Did not enroll ❒ Did not complete Reason:_____
Date Entered:_____ Date Completed:_____
Referred to Continuing Care, Level_____, on this date:_____
Treatment Provider's Signature:_____ Date:_____

2. Final Continuing Care Treatment Program Referral - Level of Care:_____
Program Name:_____
Address:_____
City/State/Zip:_____
❒ Did not enroll ❒ Did not complete Reason:_____
Date Entered:_____ Date Completed:_____
Referred to Further One Year Monitoring at Program:_____
Address:_____
City/State/Zip:_____
Months/Days of Monitoring Left to Complete_____
Treatment Provider's Signature:_____ Date:_____

G

CHEMICAL DEPENDENCY COUNSELOR'S SIGNATURE
The counselor's signature indicates that all requirements have been completed in accordance with Montana law and that the defendant is in compliance with the recommendations of the ACT program and order of the court.

Certified Chemical Dependency Counselor's Signature:_____ Date:_____